



CHILD AND ADULT CARE FOOD PROGRAM

SPONSORED FACILITY APPLICATION

Name of Center's Sponsor: _____
 Sponsor must also complete a Sponsor of Center Application.

1. Center Name: _____

Street Address: _____

CITY STATE ZIP

Mailing Address: _____

CITY STATE ZIP

Telephone #: _____ Fax #: _____

Person in charge at Center: _____ Date of Birth: _____

2. TYPE OF SPONSORED CENTER:

____ Child Care ____ Head Start ____ Adult Day Care ____ Outside School Hours ____ For-Profit

3. LICENSED: ____ Yes (Attach copy of current license.) ____ No

4. OPERATING INFORMATION:

A. Hours of Operation: From: _____ To: _____ Shift Care: ____ Yes ____ No

B. Circle Operating Days for the Week: Mon Tue Wed Thur Fri Sat Sun

C. List Dates of Non-Operation for periods of one (1) week or longer during which the CACFP will not operate, (include spring or summer break): _____

5. MEALS PROVIDED ARE: _____ Prepared on-site at the Center -OR-

____ **Obtained through a Food Service Agreement with _____
 School/Company/Center

**(Please request a Food Service Agreement form from the MT CACFP or provide a copy of the current agreement/contract in use. An agreement or contract is required and must be updated annually.)

6. MEALS THAT WILL BE SERVED AND CLAIMED: List the meals that will be served and identify the meals that will be claimed. You may only claim up to 2 meals and 1 snack or 1 meal and 2 snacks per day per participant. Meal service times must be accurate, and changes to the meal times must be submitted to the Montana CACFP in writing as they occur. **There must be at least 2.5 hours between meals claimed.**

	Place an X by All Meals to be Served	Meals	Place an X by Each Meal to Be Claimed	List the Time of Each Meal Service	If Shift Care Is Offered, List the Meal Times of the 2nd Shift Meal Service
A		Breakfast			
B		AM Supplement			
C		Lunch			
D		PM Supplement			
E		Supper			
F		PM Supplement			

Signature of "Sponsor of Centers" Representative

Date